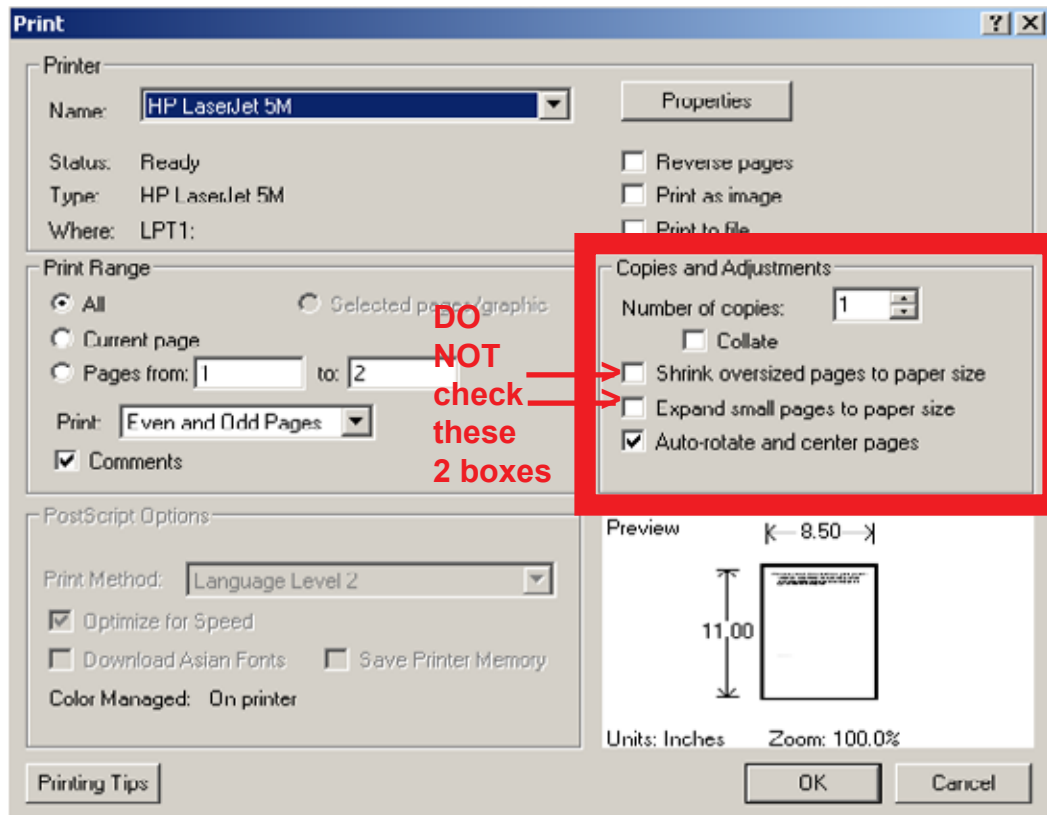


# Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or



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Health Professions Quality Assurance  
P.O. Box 1099  
Olympia, WA 98507-1099

## A. Contents:

### Dispensing Optician License Application Packet

1. 647-067 ... Contents List/SSN Information/Deposit Slip .....	1 page
2. 647-060 ... Washington State Dispensing Optician Examination Information .....	5 pages
3. 647-068 ... Application Instructions for Examination As A Dispensing Optician .....	2 pages
4. 647-071 ... Important Information Regarding Personal Data Questions .....	1 page
5. 647-007 ... Application for Examination As a Dispensing Optician .....	4 pages
6. 647-061 ... Washington State Dispensing Optician Program State Law Examination .....	2 pages
7. 647-017 ... Training Certification for Apprentice Dispensing Optician .....	1 page
8. 647-016 ... Certificate of Experience In Dispensing Opticianry .....	1 page
9. 647-018 ... Verification of Licensure Dispensing Optician .....	1 page
10. 647-052 ... Ophthalmic Dispensing Programs .....	1 page

## B. Important Social Security Number Information:

- \* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
- \* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

## C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099.**



Cut along this line and return the form below with your completed application and fees.



## Dispensing Optician

## DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section  
P.O. Box 1099  
Olympia, Washington 98507-1099

Please note amount enclosed, and return  
with your application.

\$

- ☐ Check  
☐ Money Order

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## **Washington State Dispensing Optician Examination Information**

### **I. Purpose**

The purpose of the dispensing optician examination is to assure that successful candidates possess a minimum level of practical and cognitive skills essential for the competent and safe practice of opticianry.

This examination is administered biannually, in July and January. Please contact the Department of Health at (360) 236-4948 for exact dates.

### **II. Examination Administration**

The examination is administered by the Washington State Dispensing Optician Examining Committee, program staff members, and examination proctors.

Candidates will be known to the examiners by candidate ID number only. Do not disclose your identity to the examiners.

### **III. Examination Passing Criteria**

The passing score for each portion of the examination is 70%. Any applicant obtaining a score of less than 70% in any section will be required to retake that portion of the examination.

### **IV. Written Examination**

#### **A. Contact Lens**

The contact lens portion of the written examination consists of 100 multiple-choice questions. Examination length: 1 ½ hours. Suggested topics of study are:

1. Lens design such as:
  - central posterior curve
  - diameter and thickness
  - vertex power
  - various curves of the finished lens
  - edge design
  - tint
  - lens configuration
2. Lens material.
3. Orientation and pre-fit including external observation, corneal measurement, interpretation of Rx, lens selection and ordering.
4. Lens verification.
5. Instruction and lens delivery including patient preparation, lens insertion and removal, hygiene, technique and wearing schedule.
6. Follow-up including subjective response, objective evaluation, lens modifying.

7. General knowledge criteria for a well fit contact lens.

**B. Basic Optical Concepts**

The basic optical concepts portion of the written examination consists of 150 multiple-choice questions including an eye schematic. Examination length: 2 hours. Suggested topics of study are:

1. Light, its relationship to vision and other characteristics of light as a basic element of nature and its role in optics.
2. Lenses, including material composition, various designs, laboratory procedures, prismatic characteristics.
3. Optical dispensing including:
  - transposition
  - interpretation of the Rx
  - layout and instrumentation
  - frame and adjusting and design
  - eyeglass manufacturing
  - order taking, record keeping
  - availability of products
  - optical aids
  - vertex calculating
  - pupillary distance
4. Knowledge of the physical composition of the human eye.
5. Knowledge of the relationship between parts of the eye.
6. Knowledge of the relationship between the eye and optical dispensing.
7. Functions of each part of the eye.
8. Eye disorders, including cataracts, focal length, vertex distance problems, vertical and muscle imbalance, refractive errors, eye disorders, and pathological conditions.
9. Recognize various parts of the eye.
10. Definitions.
11. ANSI Standards.

**V. Practical Examination**

- A. The practical portion of the examination is given for the purpose of determining your ability and skill to perform day-to-day functions as a dispensing optician.
- B. Each of the sections is timed; the timers will be started by the examiner before the start of each section.
- C. If you change, alter or touch the timers in any way, you will be removed from the exam IMMEDIATELY.
- D. **Do not request to be assigned to specific equipment.**

The practical examination will test your basic knowledge in the following areas:

- A. Eye Glass Identification
  - 1. Neutralization of lenses
  - 2. Identify material. Optical center, PD & thickness
  - 3. Lay out and mark up lens
- B. Contact Lens Identification
  - 1. Neutralize contact lenses
  - 2. Identify type of each contact lens
- C. Measure the Consumer
  - 1. Consumer's PD
  - 2. Consumer's vertex distance
- D. Aseptic Technique
  - 1. Proper hand washing
  - 2. Instrument cleaning
- E. Analyze the Consumer
  - 1. Keratometer reading
  - 2. Slit lamp illumination
- F. Finish edging of a lens into a metal frame.
- G. Remount semi-nylon rimless frame.
- H. Recognize common corneal stains and lens-corneal relationships and slit lamp illuminations.

## **VI. Instruments**

Instruments will be provided, candidates will not be allowed to bring their own or to request specific instruments during the examination. The following is a list of the instruments used during the practical portion of the examination:

- 1. Handstone—Robinson-Houchin ceramic
- 2. Marco Lensometer
- 3. A.O. Lensometer
- 4. Bausch & Lomb Vertometer
- 5. Marco Keratometer
- 6. Marco Radiuscope
- 7. Top Con Slit Lamp
- 8. A.O. Radiuscope
- 9. Corneal Reflection Pupilometer
- 10. Distometer Gauge
- 11. Lens Clock

12. Lensco Meter Attachment
13. Diameter Gauges
14. Stainless PD/OS 7780 Rulers
15. Calipers

## **VII. Special Needs**

If you have a condition that requires special consideration in order to take the examination, you must submit your request in writing to this office. Your written request must state the specific reason you require special consideration, as well as what special accommodations will meet your needs. Special accommodations may require confirmation from a qualified health care practitioner.

## **VIII. Examination Results**

Examination results will be released three to four weeks following the examination. No results will be given out over the phone.

## **IX. Examination Retakes**

Any candidate obtaining a score of less than 70% in any section will only be required to retake the section(s) not successfully completed. Candidates failing the examination section(s) may retake the section(s) at the next examination date. Applications for examination or examination retakes are due to the Department of Health sixty (60) days prior to the examination date.

Applicants failing to successfully pass all sections of the examination within three (3) consecutive regularly scheduled examinations shall be required to re-examination on all three (3) sections.

## **X. Examination Fees and Cancellation**

All examination fees are non-refundable. If an applicant is unable to attend his or her scheduled examination, and notifies the dispensing optician program in writing at least seven (7) days prior to the scheduled examination, the candidate will be rescheduled at no charge. Otherwise, the fee will be forfeited, however, emergencies may be considered.

### **Fees:**

\$200.00	Full Examination
\$ 25.00	Basic Concepts Re-examination
\$ 25.00	Contact Lens Re-examination
\$ 50.00	Practical Re-examination

Candidates may either use the application provided in this booklet for examination or re-examination or contact the HPQA Customer Service Center at (360) 236-4700.

**All application and fees should be sent to the following address:**

**The Department of Health  
Dispensing Optician Program  
P.O. Box 1099  
Olympia, WA 98507-1099**



Any supporting documentation or cancellation notices should be mailed to:

The Department of Health  
Dispensing Optician Program  
P.O. Box 47870  
Olympia, WA 98504-7870

## **Examination Study References**

The following textbooks are recommended as a source of study material to prepare for the Washington State Dispensing Optician Licensing Examination. Examination candidates are not required to purchase these books.

### **ANSI Standards**

American National Standards Institute (212) 642-4900

### **Ophthalmic Terminology Builder, Spelling and Vocabulary**

Mosby—Yearbook, Inc.—Stein, Slatt, Stein

### **Systems for Ophthalmic Dispensing**

Professional Press—Brooks and Boorish

### **The CIAO Guide to Basic Science and Clinical Practice**

Kendall/Hunt Publishing Co 1995—Kast, Peter R., M.D.

### **Fitting Guide for Hard and Soft Contact Lens: A Practical Approach; 3<sup>rd</sup> Edition**

Mosby—Yearbook, Inc.—Stein and Slatt

### **Test Review for Contact Lens Technicians**

Contact Lens Society of American—Caroline, Patrick J./Vickery, Jean Ann/Ward, Michael A.

### **Dictionary of Ophthalmic Optics**

Butterworth—Keeney, Arthur H./Hagman, Robert/Fratello, Cosmo J.

### **Ocular Anatomy and Physiology**

Blackwell Science—Saude, Trygve

### **Ophthalmic Dispensing Review Book**

### **American Academy of Ophthalmology Home Study Course for Ophthalmic Medical Assistants**

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## **Application Instructions For Examination As A Dispensing Optician**

### **Requirements for Licensure**

To qualify for credentialing in Washington, an applicant must:

1. Be at least 18 years or more of age.
2. Graduated from an accredited high school or received a general equivalency degree.
3. Be a citizen of the United States or have declared his or her intention of becoming such citizen in accordance with the law.
4. Has either:
  - a. Completed at least three years of apprenticeship training; or
  - b. Successfully completed a prescribed course in opticianry in a college or university approved by the secretary, or
  - c. Been principally engaged in practicing as a dispensing optician not in the state or Washington for five years.

### **Application Requirements**

1. A completed application on forms provided by the Secretary.
2. Official high school transcripts or equivalency forwarded directly from the issuing agency.
3. Official transcripts forwarded directly from the issuing agency showing successful completion of a prescribed course in opticianry from an approved school or college of opticianry (if applicable).
4. One (1) passport size photograph taken within one year of application. Sign and date the photo across the bottom and attach to the application.
5. Verification of credential status from all states and provinces where applicant has been issued a credential to practice opticianry—whether active or inactive, indicating whether the applicant is or has been subject to charges or disciplinary action for unprofessional conduct or impairment . (Form provided may be duplicated.)
6. Fee of \$200.00—Please make checks payable to Department of Health and mail with the application to: **PO Box 1099, Olympia, WA 98507-1099.**
7. Four hours of AIDS education as required in Chapter 246.12 WAC, Part 8.
8. Required documentation for affirmative responses to personal data questions.
9. Additional information as required by the secretary.

Applications will be acknowledged and deficiencies noted.

Applications will **not** be considered complete until all required supporting documents are on file with the Secretary of Department of Health.

**Supporting documents, or correspondence should be sent to:**

Department of Health  
Dispensing Optician Program  
PO Box 47870  
Olympia, WA 98504-7870

If you have any questions, please contact Health Professions Section 4 at 360-236-4825.



Health Professions Quality Assurance  
P.O. Box 1099  
Olympia, WA 98507-1099

FOR OFFICE USE ONLY

LICENSE #

ISSUANCE DATE

LICENSE #

## Application For Examination As A Dispensing Optician

Application for examination is made by:

- ☐ Apprenticeship  
☐ Opticianry School  
☐ Out-of-State Experience

**Please Type or Print Clearly**—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. Make remittance payable to the Department of Health.

### 1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE NAME OR INITIAL

ADDRESS

CITY STATE ZIP COUNTY

**NOTE:** The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)

( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

— —

GENDER

☐ Female ☐ Male

BIRTHDATE (MO/DAY/YEAR)

/ /

PLACE OF BIRTH (CITY/STATE)

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

☐ Completed High School ☐ General Education Development (GED)

### 2. Previous Licensure

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. (Attach additional 8 1/2 x 11 sheets if necessary.)

STATE OR OTHER JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE	LICENSE CURRENT?
			YEAR ISSUED	NUMBER		
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes

### 3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐
- “Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
- 1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).
- 1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.
- (If you answered “yes” to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in “1b” so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐
- “Currently”** means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.
- “Chemical substances”** includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?..... ☐ ☐
4. Are you currently engaged in the illegal use of controlled substances?..... ☐ ☐
- “Currently”** means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.
- “Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.
- Note:** If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.
5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:
- a. the use or distribution of controlled substances or legend drugs?..... ☐ ☐
- b. a charge of a sex offense?..... ☐ ☐
- c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)..... ☐ ☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:
- a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ..... ☐ ☐
- b. committed any act involving moral turpitude, dishonesty or corruption? ..... ☐ ☐
- c. violated any state or federal law or rule regulating the practice of a health care professional? ..... ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, explain and provide copies of all judgments, decisions, and agreements. .... ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ..... ☐ ☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?..... ☐ ☐

#### 4. AIDS Education And Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

#### 5. Applicant's Attestation

I, \_\_\_\_\_, certify that I am the person described and identified in  
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

**Official Use Only**  
**Washington State Records Center**



## **Important Information Regarding Personal Data Questions**

This page contains important frequently asked questions and the Department of Health answers concerning the personal data questions. You will be held responsible for this information.

**1. For questions 5a, 5b and 5c, do I need to reveal a conviction that is over three years or over five years old?**

Yes, this question asks if you have ever been convicted, etc. of any crime other than a minor traffic violation.

**2. For questions 5a, 5b and 5c, do I need to reveal a conviction that is not a felony?**

Yes, you must reveal all convictions even if they were a misdemeanor or seem minor. The only exception to this is minor traffic infractions. You must, however, reveal a DUI or a Reckless Driving Conviction.

**3. What happens if I answer “no” to a question I should have answered “yes” to?**

The Department of Health can issue a “Statement of Charges” against your application for certification based on a deceptive answer. You will have the chance to respond and, if necessary, go to a hearing regarding this matter. Be aware that this process can be quite lengthy.

If you are granted a certification based on deceptive answers to the personal data questions and the Department later finds out about this, disciplinary action can be taken against your certification at that point in time. This means your credential could be revoked based on inaccurate information on your original application.

**4. Do I need to send documentation when I answer, “Yes” to questions 5, 6, 7, 8 or 9?**

Yes, you must provide a signed and dated statement of explanation and certified copies of all judgments, decisions, orders, agreements or surrenders. If you do not send this documentation with your application, it will delay the processing of your application.

**5. What if I am convicted of a crime after I submit my application and/or received my certification?**

You are required by RCW 18.130.070(4) to report any conviction, determination or finding that you have committed unprofessional conduct or are unable to practice with reasonable skill and safety.

Please contact the Department of Health at (360) 236-4825 if you do not understand the above information.

Mail completed application and fee to:

Department of Health  
Dispensing Optician Program  
PO Box 1099  
Olympia WA 98507-1099  
(360) 236-4825

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Health Professions Quality Assurance  
PO Box 1099  
Olympia, WA 98507-1099  
(206) 236-4825

## Washington State Dispensing Optician Program State Law Examination

Please circle the correct response.

1. An unlicensed person may perform mechanical work upon inert matter in an optical office, laboratory or shop.
  - a. True
  - b. False
2. To sell completely preassembled articles such as spectacles, eyeglasses, magnifying glasses and goggles, a person must be licensed under the dispensing optician practice act (RCW 18.34).
  - a. True
  - b. False
3. A licensed dispensing optician may diagnose human ailments, deficiencies, deformities and/or injuries.
  - a. True
  - b. False
4. A dispensing optician may fit contact lenses only upon a written prescription of physician or optometrist.
  - a. True
  - b. False
5. A license to practice as a dispensing optician MUST be conspicuously displayed in the place of business of the licensee.
  - a. True
  - b. False
6. A dispensing optician may supervise a maximum of \_\_\_\_\_ apprentices at any one time.
  - a. 1
  - b. 2
  - c. 3
  - d. 5
7. A dispensing optician renews their license:
  - a. Annually
  - b. Every 2 years
  - c. Every 3 years
  - d. Every 10 years
8. How many hours of continuing education must be acquired?
  - a. 15 hours each year
  - b. 30 hours every 3 years
  - c. Varies with state of residence
  - d. Continuing education is not required
9. \_\_\_\_\_ of these credits MUST relate to contact lenses?
  - a. 5
  - b. 15
  - c. No set amount
  - d. 30
10. Who maintains a record of the licensee's continuing education hours?
  - a. Dispensing Optician Examining Committee
  - b. The Department of Health
  - c. The licensee
  - d. Opticians Association of Washington

11. Which of the following is NOT required as minimum equipment for a Washington licensed dispensing optician while fitting contact lenses?
  - a. Slit Lamp or biomicroscope
  - b. Lensometer
  - c. Keratometer
  - d. Binocular indirect ophthalmoscope
12. Washington licensed dispensing opticians shall maintain patient records a minimum of:
  - a. Seven years
  - b. Ten years
  - c. Five years
  - d. Eight years
13. Which of the following is considered unprofessional conduct?
  - a. Providing false information when applying for a license
  - b. Misrepresentation or fraud in any aspect of the conduct of the business or profession
  - c. False or misleading advertising
  - d. All of the above
14. A notation of "OK for contacts" on the prescription for corrective lenses indicates to the practitioner fitting the contact lenses that:
  - a. The patient has been provided with trial lenses
  - b. The patient has expressed an interest in wearing contact lenses
  - c. The initial fitting and follow-up must be completed within six months of the date of the eye examination
  - d. The patient's vision plan covers contact lenses
15. A prescription may be written for less than two years if:
  - a. Warranted by the ocular health of the eye
  - b. The prescription is for extended wear contact lenses
  - c. The patient is new
  - d. The prescription is more than plus or minus three diopters
16. If a prescription is written for less than two years, the prescriber must:
  - a. Contact the optical lab
  - b. Send a notice to the patient prior to its expiration
  - c. Maintain a separate log of prescriptions that expire in less than two years
  - d. Enter an explanatory notation in the patient's record and provide a verbal explanation to the patient at the time of the eye examination
17. No practitioner may dispense contact lenses based on a prescription that is over:
  - a. One year old
  - b. Five years old
  - c. Two years old
  - d. Three years old
18. The finalized contact lens prescriptions shall be available to the patient or the patient's designated practitioner for replacement lenses and may be transmitted by:
  - a. Telephone
  - b. Facsimile or mail
  - c. Provided directly to the patient in writing
  - d. All of the above



Health Professions Quality Assurance  
Dispensing Optician Program  
PO Box 1099  
Olympia, WA 98507-1099  
(360) 236-4825

## Training Certification for Apprentice Dispensing Optician

NOTE: Use this form to **document total apprenticeship training hours** when the apprenticeship supervision has terminated.

### Please Type or Print Clearly

Supervisor's Full Name \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Daytime Telephone Number \_\_\_\_\_

Licensed to practice as: ☐ Physician ☐ Optometrist ☐ Dispensing Optician

License Number \_\_\_\_\_

### I certify that

(Apprentice's Name), \_\_\_\_\_

has been under my direct supervision as an Apprentice Dispensing Optician for the period:

beginning \_\_\_\_\_  
MONTH DAY YEAR

and ending \_\_\_\_\_ and has accrued a total of \_\_\_\_\_ apprenticeship  
MONTH DAY YEAR

hours while under my supervision.

I, \_\_\_\_\_, certify that  
PRINT OR TYPE FULL NAME OF DIRECT SUPERVISOR

I am the person identified above as the supervisor and that to the best of my knowledge and belief the statements made in this affidavit are true and correct.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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## **Certification of Experience In Dispensing Opticianry**

### **Candidate Instructions**

A separate copy of this form should be used to certify each position claimed as work experience outside of the state of Washington. It is the applicant's responsibility to have this form fully completed by their previous employer. This form should be submitted to the above address by each previous employer.

### **Section I—To be completed by the Applicant—Please Print**

FULL NAME UNDER WHICH APPLYING

PREVIOUS OR OTHER NAME(S) USED

STREET ADDRESS

CITY	STATE	ZIP	TELEPHONE NUMBER (      )
------	-------	-----	------------------------------

SIGNATURE OF APPLICANT

### **Section II—To be completed by the Employer—Please Print**

I certify that the applicant named above was employed by:

NAME OF FIRM OR AGENCY

STREET ADDRESS

CITY	STATE	ZIP
------	-------	-----

for a period of \_\_\_\_\_ months from \_\_\_\_\_ to \_\_\_\_\_. The applicant was actually and primarily engaged in the practice of a dispensing optician.

Under penalties of perjury, I declare and affirm that the above statements are true, complete and correct.

SIGNATURE OF EMPLOYER/AUTHORIZED AGENT

POSITION IN FIRM

ADDRESS

DATE

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Health Professions Quality Assurance  
PO Box 1099  
Olympia, WA 98507-1099  
(206) 236-4825

## Verification of Licensure Dispensing Optician

**TO APPLICANT:** Complete top portion in full and forward to state in which you hold or have held a license/certificate as a Dispensing Optician (there may be a fee for this service).

Name (Last, First, Middle Initial) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

License No. \_\_\_\_\_

I authorize the release of the information asked for below to the Washington State Dispensing Optician Program.

Signature \_\_\_\_\_

All fees are the responsibility of the licensee named above.

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**TO STATE BOARD:** The above individual is applying for licensure as a Dispensing Optician in Washington State. To assist the Board in their review, please complete the following information and return to the above address. Thank you for your cooperation.

Name of Licensee \_\_\_\_\_

License No. \_\_\_\_\_ Date of Issue \_\_\_\_\_ Expiration Date \_\_\_\_\_

License was issued on the basis of:

☐ Examination in your state: ☐ Written Examination ☐ Practical Examination

☐ NCLE Examination ☐ ABO Examination

☐ Reciprocity/Endorsement from (indicate state) \_\_\_\_\_

☐ Registration (no examination required)

☐ Other (explain) \_\_\_\_\_

Legal/disciplinary action? ☐ Yes ☐ No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

SEAL

\_\_\_\_\_  
SIGNATURE OF VERIFIER

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
STATE BOARD

\_\_\_\_\_  
DATE

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Washington State Department of  
**Health**  
Health Professions Quality Assurance  
Dispensing Optician Program  
PO Box 1099  
Olympia, WA 98507-1099

## **Ophthalmic Dispensing Programs**

Middlesex Community College  
100 Training Hill Rd.  
Middletown, CT 06457  
203 344-7599

Hillsborough Community  
College  
PO Box 30030  
Tampa, FL 33630  
813 253-7000

Miami-Dade Community  
College  
950 NW 20th St.  
Miami, FL 33127  
305 237-4032

DeKalb Technical Institute  
495 N Indian Creek Dr.  
Clarkston, GA 30021  
404 297-9522, Ext. 207

Mt. Ida College  
777 Dedham St.  
Newton Centre, MA 02159  
617 969-7000, Ext. 324

Ferris State University  
VFS 424  
Big Rapids, MI 49307  
616 592-2224

Camden County College  
PO Box 200  
Blackwood, NJ 08012  
609 227-7200, Ext. 322

Essex County College  
303 University Ave.  
Newark, NJ 07102  
973 877-3367

Southwestern Indian  
Polytechnic Institute  
9159 Coors Rd NW  
Albuquerque, NM 87184  
505 897-5359

Erie Community College  
6205 Main St.  
Williamsville, NY 14221-7095  
716 634-0800, Ext. 400

Interboro Institute  
450 W 56th St.  
New York, NY 10019  
212 399-0091

Mater Dei College  
Riverside Dr.  
Ogdensburg, NY 13669  
315 393-5930

New York City Technical College  
300 Jay St.  
Brooklyn, NY 11201  
718 260-5298

Durham Technical Community  
1637 Lawson St.  
Durham, NC 27703  
919 598-9239

Cuyahoga Community College  
2900 Community College Ave.  
Cleveland, OH 44115  
215 987-4000

Roane State Community  
College  
Patton Ln.  
Harriman, TN 37748  
615 882-4594

El Paso Community College  
PO Box 20500  
El Paso, TX 79998  
915 594-2000

J. Sargeant Reynolds  
Community College  
PO Box 85622  
Richmond, VA 23285  
804-786-5298

Naval Ophthalmic Support  
and Training Activity/Thomas  
Nelson Community College  
Yorktown, VA 23691  
804 887-7148

Seattle Central Community  
College  
1701 Broadway  
Seattle, WA 98122  
206 344-4321

### **Programs In Progress:**

Anoka Technical College  
Anoka, MN

Raritan Valley Community  
College  
Somerville, NJ

Worcester Technical Institute  
Worcester, MA